Bayfield Schools Annual Student Health Information

Student:_____Grade: _____ School Year _____ Doctor Name:_____

Parent/Guardian Name:_____ Best Daytime phone #:_____

	YES	NO	Explanation of medical concern (glasses, allergic to bees, lactose intolerant, etc.)
Physician diagnosed Vision Problems			
Physician diagnosed Hearing Problems			
Physician diagnosed Speech Problems			
Physician diagnosed Dietary Restrictions			
Physician diagnosed restrictions on Physical Activity			
Physician diagnosed Seizures			
Physician RX - Epi-Pen			
Physician diagnosed Severe Allergies			
Physician diagnosed Diabetic			
Physician diagnosed Asthma ***see other - side			
Other Medical Concerns we need to be aware of			

1. Has your child been seriously ill or hospitalized during the last year? Yes No

   If **yes,** please explain and include the diagnosis, physician, and hospital:_____

   _____

2. Does your child require any health services during the school day? Yes No

   If **yes**, what type of services are needed?_____

3. Is your child taking any medication on a regular basis? Yes No

   If **yes**, please name the medication and the reason_____

4. Does this medication need to be administered during the school day? Yes No

If **YES**: **ALL MEDICATION MUST BE CHECKED INTO THE HEALTH OFFICE & yearly paperwork will need to be signed**

I give permission that the pertinent health information regarding the above named student be given to the appropriate school personnel at the discretion of the district nurse and health aide.

Signature of parent/guardian:_____Date:_____

>>PLEASE FILL OUT IF YOUR CHILD HAS **Physician Diagnosed** **ASTHMA**<<

Does your child have **Physician diagnosed** asthma? Yes No

If **yes**, please complete the following:

*When was the child's last asthma attack?_____

*How often does your child have an acute episode?_____

*Does your student do breathing exercises that are helpful in managing their asthma?

_____

*Does exercise induce episodes of asthma? Yes No

If **yes,** please explain:_____

*Do certain weather conditions affect your child's asthma? Yes No

If **yes**, which type of conditions and what actions do you normally take?_____

_____

*Does your student understand their asthma and how to help manage it? Yes No

*How do you want the school to treat an asthma episode?_____

_____

*Should the asthma medication be kept and used at school? Yes No

If **YES**: **ALL MEDICATION MUST BE CHECKED INTO THE HEALTH OFFICE & yearly paperwork will need to be signed**

*If your child is not responding to the medication, what action do you advise the school health office to take?_____

Is there anything (medically) that you would like the District Nurse and/or Health Aides to know about your student for the school year?

_____
_____
_____
_____
_____
_____
_____